CHAPTER 6

CASE MANAGEMENT IN THE S/HMO DEMONSTRATIONS

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INTRODUCTION

This chapter compares and contrasts case management departments and case management roles and activities across the four S/HMO demonstration sites: Medicare Plus II in Portland, Oregon; Elderplan in Brooklyn, New York; Seniors Plus in Minneapolis, Minnesota; and SCAN Health Plan (SHP) in Long Beach, California. First, eligibility criteria for chronic care benefits and case management at each site are compared, followed by a description of the resultant case mix of members receiving chronic care benefits and case management. The next section diagrams the case management component fit within the S/HMO organizational structure and describes the principal activities undertaken by the case management department at each site. Case management staffing patterns and caseloads are then compared, followed by a cross-site comparison of the costs of case management. The final section assesses the strength of the linkages that had been developed between the case management component of the S/HMO and the larger health care system at the end of the second year of the demonstration and identifies issues and questions to be examined in subsequent analyses.

BACKGROUND

In each of the demonstrations it was the case management component of the S/HMO that was given responsibility for managing the nonacute, long term care services. In the S/HMO, the role and authority of the case managers was envisioned as much broader than in earlier long term care demonstrations. In most earlier demonstrations, the case manager role focused primarily on screening/assessment and the coordination and/or provision of community-based care (Austin, 1983; Berkeley Planning Associates, 1985; Zawadski, 1984). In the S/HMO, the case manager was to have primary responsibility for authorizing all long term care services, responsibility for monitoring the chronic care services and budget, and final authority over chronic care resource allocation. Beyond this, it was hoped that the case management component would also be able to establish new norms of practice regarding linkages with other components of the health care system that would ultimately lead to care of high quality delivered in an equitable manner, but would at the same time hold chronic care costs of the enrolled population to budgeted levels.

Within these broad goals and objectives, each demonstration site was permitted flexibility in developing its case management model. As implemented, no two case management models were the same. In large part, the differences were a reflection of initial program design decisions, which subsequently influenced the case management model and approach.

METHODOLOGY

Data on S/HMO case management and chronic care services were collected from the four demonstration sites. Qualitative data on the organizational structure, roles, and staffing patterns of the case management department were obtained from interviews with the director of case management, the case

managers, and other selected S/HMO staff. Interviews were also conducted with representatives from the utilization review and discharge planning staffs of hospitals and nursing homes affiliated with and serving S/HMO members. The interviews were conducted during site visits in the fall and winter of 1986. This chapter also includes background information about planning decisions made during the S/HMO developmental period in 1983 and 1984. Statistical data on the utilization and costs of case management services, and other aspects of the S/HMO, were obtained from unaudited S/HMO quarterly reports submitted to HCFA.

This chapter covers information and statistical data from the first two years of the S/HMOs, which began enrollment in 1985. Throughout this chapter, emphasis is placed on the 1986 data, which represents a more stable program period and is less susceptible to variations experienced during the initial start-up period. It is important to note that the S/HMOs are an evolving system and, as such, there have been some important changes in case management and its activities since this report was prepared. The information provided here describes S/HMO case management as it functioned at the close of the second year of the demonstration.

ELIGIBILITY CRITERIA FOR CHRONIC CARE BENEFITS AND CASE MANAGEMENT SERVICES

HCFA did not restrict the S/HMO demonstrations concerning which members should be eligible to receive expanded long term care benefits. Eligibility decisions were left to individual sites and reflected the sites' overall philosophy and policy concerning the distribution of chronic care resources.

The financing of acute care services has traditionally been relatively open-ended, whereas financing for long term care services has been more contained. For example, since the 1970s, all HCFA-supported long term care demonstrations have, with varying success, applied eligibility criteria in an effort to effectively target their services to those for whom long term care would be most beneficial and cost-effective.

The results of the recently completed National Long term Care Channeling Demonstration, as well as most earlier long term care demonstrations conducted under Medicare and/or Medicaid waivers, suggest that expanding community-care programs beyond what is currently provided would not by itself reduce public expenditures for long term care. Nonetheless, the results of these demonstrations suggested several potentially promising approaches to improving the long term care system such as linking the provision of community services to a nursing home preadmission screening process.

The similarity of the earlier demonstration approaches -- providing modest amounts of extra community service to those in need and coordinating them through a central case management system -- left open the question of whether different organizational approaches for the provision of long term care services might produce better results (U.S. HCFA, 1987). The S/HMO organizational model in which a single provider entity assumes responsibility

for both acute and long term care services under a fixed, prospectively determined budget represents one such approach.

The S/HMO demonstrations operated under several important constraints that dictated the need for careful, selective targeting of the membership eligible for chronic care benefits. First, the chronic care benefits were by design restrictive in terms of the total dollar resources available for each eligible enrollee. Second, there could potentially be a large demand for long term services that would exceed the overall projected budget. Third, the demonstrations were eventually to be financially at risk for all long term care services. Consequently, key program decisions had to be made about who among the S/HMO membership should be eligible for the expanded long term care services.

During the developmental phase of the demonstration, the issue of targeting and eligibility was discussed at length (Leutz et al., 1985). Two positions emerged. On the one hand, early intervention with members who are only moderately impaired could prevent or delay functional decline and concommitant high service costs, and could prove cost-effective over time. On the other hand, the limited S/HMO budget for long term care services might make it prudent to limit chronic care benefits to the most impaired, frail members.

Ultimately, the decision regarding eligibility for chronic care benefits was linked to a person's level of impairment. In addition, since the demonstrations were to be paid a higher rate for members who were nursing home certifiable (NHC), it seemed equitable to link eligibility for the chronic care services, at least in part, to NHC status.

All of the sites adopted this approach; however, there were significant differences in the four states' criteria for nursing home certification. Furthermore, each site still had the option of deciding to be more or less strict than the state criteria. One of the primary reasons for giving the demonstrations latitude in defining eligibility for the chronic care benefit was to see how services could best be targeted to impaired elderly, working within tight budget constraints.

In the sections below, the NHC criteria for each site are compared; then expansion of the NHC eligibility criteria to allow more members access to chronic care benefits and case management is described. Next, a special program feature (queuing) designed to safeguard against adverse case-mix among the membership is described. Finally, case-mix differences in the membership of each site at the end of the second year of the demonstration are assessed.

NURSING HOME CERTIFICATION CRITERIA

There was considerable variation among nursing home certification criteria in the four states. As shown in Figure 1, there were only nine health-related criteria variables common to all sites: mobility, cognition, ability to eat/feed oneself, ability to use the toilet, and ability to manage

Figure 1

VARIABLES INCLUDED ON THE NURSING HOME CERTIFICATION FORM AT THE S/HMO SITES

	Medicare Plus II	Elderplan	Seniors Plus	SCAN Health Plan
Activities of Daily Living				
Eating/Feeding	X	X	X	X
Toileting	X	X	X	
Bathing		X	X	X
Dressing and Grooming		X	X	X
Transferring	X	X	X	X
Continence				
Bladder Incontinence	X	X	X	
Bowel Incontinence	X	X	X	
Mobility				
Ambulation	X[a]	X	X	X
Wheeling	X	X	X	X
Need for Restraint	X		X	
Sensory Impairment				
Vision		X	X	X[b]
Hearing		X	X	X[b]
Communication		X[c]	X	X
Psychobehavioral Problems				
Disoriented	X	X[d]	X	X
Judgment	X	X	X	X
Regressive		X	X	X
Agitated	X	X	X	X
Restraint Order	X	X		X
Hallucination		X	X	X
Depression			X	X
Abusive	X	X	X	X
Assaultive	X	X	X	X
Wandering	X		X	X
Nursing Care and Therapy[e]				
Parenteral Meds		X	X	X
Inhalation Treatment		X	X	X
Oxygen		X	X	X
Suctioning		X	X	X
Ascetic Dressing		X	X	X
Lesion Irrigation		X	X	X
Cath/Tube Irrigation		X	X	X
Ostomy Care			X	X
Parenteral Fluids		X	X	X
Tube Feeding		X	X	X
Bowel/Bladder Rehabilitation		X	X	X
Bedsore Treatment		X	X	X
Indwelling Catheter			X	X
Other (Describe)		X	X	X
Minor Skin Care and Dressing			X	X
Intake and Output			X	X
Vital Signs Every Four Hours			X	X
Special Diet				
Health Condition[f]	X			
Other Service Needs				
Rehab Services			X	X
Medications	X	X	X	X
Skilled Therapy		X		

[a]Called 'mobility' in Medicare Plus II.

[b]Vision and hearing were combined into one item.

[c]In Elderplan, the variable was 'speech', but some of the categories were similar to those used at the other sites in the variable called 'communication.'

[d]This variable was called 'alert' in Elderplan; it is not clear how comparable it is to 'orientation.'

[e]In order to categorize any individual as nursing home certifiable, points were assigned to categories of these variables. However, each site's scoring system varied, so it was very difficult to compare total scores derived.

[f]For Medicare Plus II, this measure of the frequency of nursing assistance required is noted under health conditions including the specific nursing and therapies itemized on other site forms.

medications. Beyond this, there were numerous differences among the four sites in the use of additional criteria variables and of operational definitions and relative weighting of these variables in determining eligibility. Beyond this, even though a site might not have a specific variable on its form, e.g., bedsore treatment, this factor would be taken into consideration when making the NHC determination. Consequently, only rough comparisons could be made.

In general, based on a review of the criteria variables and their definitions, nursing home certification criteria were the most stringent in Medicare Plus II followed by Elderplan, Seniors Plus, and SCAN Health Plan. Thus, while each site paralleled its state NHC form and guidelines to qualify a member for chronic care benefits (and a higher reimbursement rate), the NHC criteria were by no means parallel across the four demonstrations.

EXPANDED ELIGIBILITY CRITERIA

Beyond the NHC criteria, each site chose to expand its eligibility criteria and provide at least some services to members who were not nursing home certifiable. Thus, the membership eligible to receive chronic care services and/or case management was determined by interrelated factors: the stringency of state NHC criteria and the site's application of these criteria; the extent to which the site permitted provision of chronic care services to less impaired members; and the extent to which the site provided case management services to members who did not qualify for chronic care services. As shown in Figure 2, the four demonstrations can be placed on a continuum ranging from the most restrictive to the least restrictive eligibility criteria for the chronic care benefits and/or case management services.

Medicare Plus II made a conscious decision to adhere to strict eligibility criteria, a decision that was guided by the demonstration site's principal focus — learning to underwrite a long term care benefit. Among the four sites, Medicare Plus II used the most restrictive criteria for eligibility to receive chronic care benefits. To qualify, a member had to be nursing home certifiable and at "high risk" of nursing home placement, meeting one of the following criteria: cannot walk, needs continuous assistance; needs total help with feeding or intravenous feeding; dangerous, violent, abusive, or needs physical restraint; frequently confused or physically wanders; highly impaired health status, bedbound, needs full-time nursing-medical care to maintain vital bodily functions; cannot manage medications, needs daily help; needs total help to use toilet or cannot use; incontinent three to five times per week, needs help three to five times per week, or total help.

During the first two years of the demonstration, there was a "loophole" in Oregon's NHC criteria which qualified a person as NHC if he/she was incontinent, but was otherwise functionally independent and healthy. In January 1987, at HCFA's request, the NHC criteria were revised to be consistent with the state's new interpretation of the incontinence criterion The scoring for incontinence was adjusted to correct for this inconsistency

Figure 2

ELIBILITY CRITERIA FOR CHRONIC CARE BENEFITS AND CASE MANAGEMENT

	Medicare Plus II	Elderplan	Seniors Plus	SCAN Health Plan
Eligibility criteria for chronic care services	Must be Nursing Home Certifiable meeting strict criteria that result in "high" or "very high" probability of nursing home placement	Must be Nursing Home Certifiable (SNF or ICF)	Nursing Home certifiable (SNF or ICF), or moderately impaired members for whom early intervention could prevent deterioration	Eligible for admission to a SNF or ICF based on state level-of-care criteria, or "at risk" of nursing home placement based on clinical judgment, or moderately impaired members
Eligibility criteria for case management services	Any member who was moderately or severely impaired who needed monitoring or any member "at risk" due to an unstable social or medical situation	Any member who was severely impaired or "at risk" due to an unstable social or medical situation	Any member ranging from those who were severely or moderately impaired to well members who only needed information and referral	Any member who was severely or moderately impaired, and hospitalized members who were functionally independent but needed short-term case management

Most Restrictive Criteria ----------> Least Restrictive Criteria

between impairment and service needs.

During the first two years of the demonstration, Medicare Plus II also provided case management services to some members not eligible for chronic care benefits, but judged to need monitoring by a case manager. It was reported, however, that there would be less monitoring of non-NHC members in the future.

At Elderplan, the eligibility criteria for chronic care benefits became slightly more restrictive over time. Initially, the eligibility criteria were based on the New York State "adapted" nursing home preadmission screening form (the DMS-I), which takes into consideration impairment and service needs related to home care (i.e., meal preparation, mobility, and walking) as well as the need for nursing home care, which the original DMS-I form was designed to assess. During the second year, the site began to strictly adhere to the original DMS-I form and scoring system. To qualify for chronic care services, a member had to meet the state criteria for a Skilled Nursing Facility or a Health Related Facility.

Elderplan provided case management services for members who were not nursing home certifiable. Each case manager had a small number of clients who were neither nursing home certifiable nor severely impaired, and who were not receiving any chronic care services but had been formally assessed and found to be in need of monitoring due to an unstable medical or social situation.

Seniors Plus eligibility criteria for chronic care benefits and case management stated that the person must be nursing home certifiable or at risk of nursing home placement, based on the preadmission screening form developed by Hennepin County. The "at-risk" criteria allowed for a substantial amount of clinical judgement by the case managers. About one-half of the clients receiving services were NHC and about one-half were classified at risk.

In addition to clients actively receiving chronic care services, each of the case managers also had a sizeable caseload of clients who were being monitored on an ongoing basis due to changing health and/or social situations. The caseload mix reflected the original Seniors Plus intent to cast a broad net and provide preventive services. On the other hand, it was also reported that based on experience gained to date, the demonstration was considering clarifying and tightening the long term care eligibility criteria for at-risk members.

The demonstration site with the least restrictive eligibility criteria for chronic care benefits and case management was SCAN Health Plan (SHP). Several factors explained the less restrictive eligibility criteria. First, the demonstration was designed, in part, to test the impact of preventive care for at-risk elderly. Second, California's nursing home determination criteria allowed for considerable professional judgment and leeway regarding nursing home certification. Third, SHP provided short-term chronic care services and case management to hospitalized members. Fourth, in comparison to the other demonstration sites, SHP elected to provide regular monthly case management

follow-up for members who were severely or moderately impaired but were not actively receiving chronic care services. In June 1987, SHP, citing fiscal reasons, presented a proposal to HCFA to change its eligibility criteria and offer chronic care services only to members certified as NHC.

QUEUING

Based on the stringency of its eligibility criteria, the sites estimated between 5 and 14 percent of the membership would use chronic care benefits at any one time (Leutz et al., 1985). However, uncertainty about biased selection was a major issue in the S/HMO. Because the proportion of long term care benefit users was projected to be small, even minor variations from projected use could potentially place the sites in financial jeopardy and strain the service delivery system.

To protect against an unbalanced selection (i.e., a larger proportion of impaired members than was found in the aged population in the area), the sites were given the option of queuing. Developed by Brandeis University, the queuing mechanism categorized applicants according to their level of functional impairment. The specific queuing categories were:

- Severely Impaired: needs assistance in activities of daily living (ADL) (bathing, dressing, eating, toileting, transferring) or is bedbound;
- Moderately Impaired: does not need ADL assistance and is not bedbound, but must stay in the house most or all of the time, needs the help of another person in getting around, needs a device (a cane, walker, or wheelchair) to get around, or has trouble getting around freely; and
- Unimpaired or Mildly Impaired: does not need ADL assistance and is not bedbound, does not have trouble getting around freely.

The purpose of queuing was to maintain a case-mix in the S/HMO population with distributions on levels of functional impairment representative of the distributions estimated for the community. Based on data available from national surveys of the elderly (1972 Health Survey; 1977 Current Medicare Survey; 1977 Health Interview Study) and the best data available on community distributions, estimates of impairment were developed for each site ranging from 3 to 6 percent for the severely impaired, from 13 to 17 percent for the moderately impaired, and from 72 to 82 percent for the unimpaired or mildly impaired (Leutz et al., 1985).

The S/HMO Application Form contained a set of questions about the applicant's level of functional impairment. All applications were reviewed by the membership services department, and when the proportion of S/HMO enrollees in either the severely or moderately impaired categories exceeded the community estimates, the site was permitted to place the applicant on a waiting list until more unimpaired persons became members.

Only three of the sites chose to use queuing -- Elderplan, Seniors Plus,

and SCAN Health Plan. Medicare Plus II elected not to queue preferring to achieve the desired balanced enrollment through effective marketing.

As the data in Table 1 show, two sites had sizeable queues at the end of the fourth quarter of 1986. At Elderplan, the queue contained 123 people, who, if admitted, would have increased the severely impaired membership at the end of the fourth quarter of 1986 from 4.1 to 8.6 percent. Similarly, at Seniors Plus the queue contained 87 people who, if admitted, would have increased the severely impaired membership from 7.2 to 11.8 percent.

MEMBERSHIP CASE-MIX

Given the differences in the eligibility criteria and processes at the four sites, it was not surprising to find that different groups of members were deemed eligible for chronic care services. Table 2 shows the number and proportion of the S/HMO membership who were nursing home certifiable, members who were receiving chronic care services, and members who were receiving case management services only during the fourth quarter of 1985 and 1986. Also shown, where available, are site projections made about case-mix when planning the S/HMO. These data show there was considerable variability between sites, as well as within a site over time, in the proportion of NHC members, as well as the proportion of members receiving chronic care services and case management only. Medicare Plus II projected that only 5 percent of its membership would be NHC at time of enrollment and that 5 percent would be receiving chronic care services at any one time. By the fourth quarter of 1986, there were 4,300 S/HMO members; 6.7 percent were NHC, but only 4.5 percent were receiving chronic care services. Another 4 percent of the members were receiving case management services only (i.e., periodic monitoring). The proportion of NHC members was larger than the proportion of members receiving chronic care for two reasons. First, the informal caregivers of some NHC members were providing all the needed services. Second, as mentioned above, a "loophole" in the NHC criteria qualified some incontinent members as NHC who did not actually need services. Thus, only 67 percent of the NHC members were receiving chronic care services.

Elderplan projected that 13.8 percent of its membership would be impaired and using chronic care services at any given time. This projected figure was the highest of the four sites, reflecting a conservative planning approach and uncertainty in predicting who would be qualified as NHC using state criteria.

By the fourth quarter of 1986, the S/HMO had 2,502 members; 4.1 percent of the members were NHC; only 2.9 percent were receiving chronic care services, and another 2.6 percent were receiving only case management services. The actual case mix was clearly different (i.e., less impaired) than in original projections. Like Medicare Plus II, the proportion of NHC members was larger than the proportion of members receiving chronic care services. Approximately 71 percent of the NHC members were receiving chronic care services.

Seniors Plus projected that 4.3 percent of its members would be NHC, but

Table 1

NUMBER OF APPLICANTS IN S/HMO QUEUE[a]

	4th Quarter 1985	4th Quarter 1986
Elderplan		
Severely Impaired	29	123
Moderately Impaired	6	0
Seniors Plus		
Severely Impaired	14	87
Moderately Impaired	0	0
SCAN Health Plan		
Severely Impaired	0	0
Moderately Impaired	0	0

Source: S/HMO Demonstration Quarterly Reports, October through December, 1985 and October through December, 1986.

[a]Medicare Plus II chose not to use the queuing process.

Table 2

CASE-MIX COMPARISONS ACROSS SITES

(Number and proportion of membership)

	1985			1986		
	No.	Percent of Membership	Projected Membership	No.	Percent of Membership	Projected Membership
Medicare Plus II						
Nursing Home Certifiable Members	134	4.2%	5.0%	289	6.7%	5.0%
Members Receiving Chronic Care Services[a]	109	3.4	5.0	195	4.5	5.0
Members Receiving Case Management Only	178	5.6	N/A	176	4.0	N/A
Total Membership	3189			4800		
Elderplan						
Nursing Home Certifiable Members	58	7.5	5.0	103	4.1	13.8
Members Receiving Chronic Care Services[a]	37	4.8[b]	13.8	73	2.9[b]	13.8
Members Receiving Case Management Only	52	6.0	N/A	65	2.6	N/A
Total Membership	770			2502		
Seniors Plus						
Nursing Home Certifiable Members	50	11.5	4.3	122	7.2	4.3
Members Receiving Chronic Care Services[a]	60	13.8[b]	8.5	185	11.0[b]	8.5
Members Receiving Case Management Only	35	8.0	N/A	140	8.2	N/A
Total Membership	433			1688		
SCAN Health Plan						
Nursing Home Certifiable Members	46	4.0	4.0	114	5.5	4.0
Members Receiving Chronic Care Services[a]	100	8.7	10.0	250	12.1	10.0
Members Receiving Case Management Only	28	2.4	N/A	162	7.9	N/A
Total Membership	1142			2061		

Source: S/HMO Demonstration Quarterly Reports, October through December, 1985 and October through December, 1986.

[a]Medicare Plus II and Elderplan did not include members who received only transportation services or durable medical equipment in their counts of members receiving chronic care services. Seniors Plus includes members who receive only transportation services. SCAN includes members who receive either/or transportation and durable medical equipment.

[b]The queue to safeguard against biased selection was being used at the end of the quarter.

8.5 percent of its members would be receiving chronic care services -- a reflection of expanded eligibility criteria and a preventive approach. By the fourth quarter of 1986, the S/HMO had 1,688 members; 7.2 percent of the members were NHC; 11.0 percent were receiving chronic care services, and an additional 8.2 percent were receiving only case management services. The case-mix reflected the Seniors Plus emphasis on providing chronic care services for preventive purposes.

Like Seniors Plus, SCAN Health Plan (SHP) projected that a larger proportion of its membership would receive chronic care services (10.0%) than would be NHC (4.0%). Like Seniors Plus, the SHP case-mix projections were somewhat low, and the membership was more impaired than anticipated. By the fourth quarter of 1986, SHP had 2,061 members; 5.5 percent of the members were NHC; 12.1 percent were receiving chronic care services, and 7.9 percent were receiving only case management services.

- There were apparent inconsistencies between the stringency of state NHC criteria and the proportion of members ultimately determined to be NHC. For example, why did SCAN Health Plan with its seemingly liberal NHC criteria have relatively few NHC members? Why did Seniors Plus, with its fairly tight NHC criteria, have so many NHC members? Why did the proportion of NHC members increase at two sites (Medicare Plus II and SCAN Health Plan) and decrease at the other two sites (Elderplan and Seniors Plus) during the second year of the demonstration?

- Queuing was designed to safeguard against biased selection, yet the data suggest that queuing was not working as intended. For example, during the fourth quarter of 1986, Elderplan had a queue of 123 severely impaired applicants (see Table 1), yet both the proportion of members who were NHC (4.1%) and the proportion of members actually receiving chronic care services (2.9%) were well below the projected proportion of severely impaired members (5.5%). Given these data, why was the queue operating? It appears that at least a portion of the applicants on the queue should have been admitted to the S/HMO.

- These data also indicate a need for better data to project impaired membership. By the end of the fourth quarter of 1986, there was considerable variation between the projections and the actual impaired membership. Since these projections also reflected budget assumptions about the S/HMO, this variation potentially becomes an important issue. These unanticipated findings regarding case-mix in the S/HMO and the questions raised will be explored in subsequent evaluation reports.

PRIMARY CASE MANAGEMENT ROLES

In large part, the roles, responsibilities, and authority given to the case management component of the S/HMO demonstrations were determined by the organizational model. The organizational model was also a key determinant of case management department linkages to the larger S/HMO delivery system. Indeed, the organizational model often determined whether the case managers

had direct control over a function/service or whether the case manager's role was primarily that of coordinating with an existing health care provider.

By design, the S/HMO demonstrations were allowed flexibility in developing their organizational models "as long as the responsibility for integrating the full range of acute and long term care services was assumed by an identifiable agency or a group of agencies acting in concert" (Leutz et al., 1985).

Figures 3-6 summarize the linkages between the components of each of the four S/HMO delivery systems and the case management functions. A more detailed discussion of case management department linkages with the S/HMO service delivery system is provided in Attachment A.

A number of the roles of the case managers at each of the sites were quite similar and tended to reflect traditional case management functions (e.g., assessment, care planning, and service arrangement). The primary differences in case manager roles among the four demonstrations were related to utilization review and discharge planning functions. Figure 7 highlights the similarities and differences in case management roles at the four S/HMO sites.

SCREENING/ASSESSMENT

All of the sites designated the case management component of the S/HMO as the member's single entry point into the long term care system. The site case management directors worked in conjunction with Brandeis University, which provided technical assistance to the S/HMOs in order to develop two principal screening/assessment instruments for the S/HMO: the baseline Health Status Form (HSF) and the Comprehensive Assessment Form (CAF). Many of the procedures for screening and assessing the S/HMO members for eligibility for chronic care services were similar at each site, but there were also important differences.

Each new enrollee in the S/HMO received by mail an HSF with questions concerning the member's health status, functional limitations, prior and current utilization of acute and long term care services, and sociodemographic information. At all sites, the case management department was responsible for reviewing the HSF and conducting a followup telephone screen to obtain missing information or clarify responses. As case management caseloads grew, telephone screens were conducted less frequently. The HSF was used to make an initial determination about eligibility for chronic care services. At all sites, members classified as unimpaired or mildly impaired were not eligible for chronic care benefits or case management unless their health status declined at a later date.

In accordance with their original site protocols, the sites used different standards to determine who should receive the in-person Comprehensive Assessment Form (CAF) that was used to make a final determination about eligibility for chronic care benefits. At Medicare Plus

Figure 3

CASE MANAGEMENT LINKAGES WITH THE S/HMO DELIVERY SYSTEM: MEDICARE PLUS II

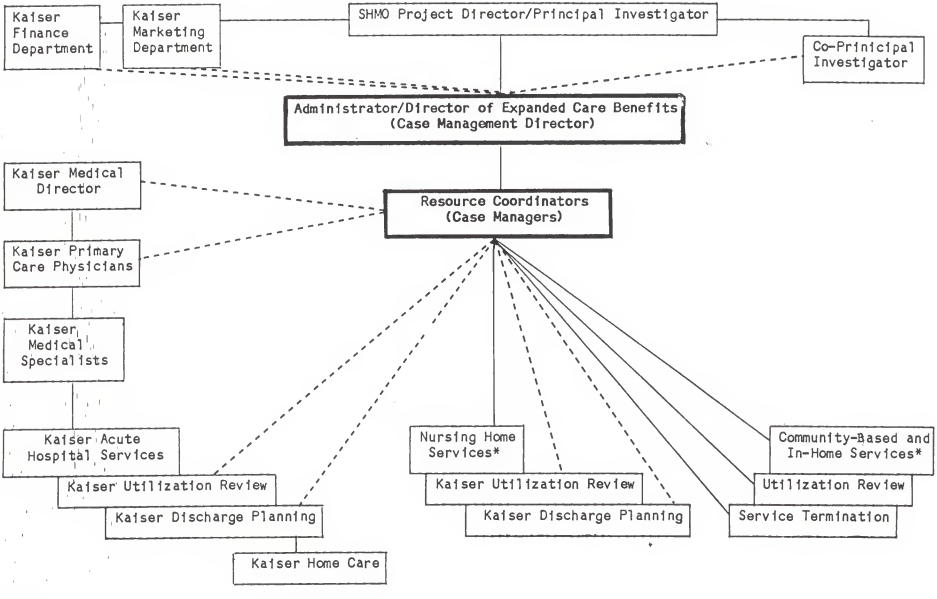
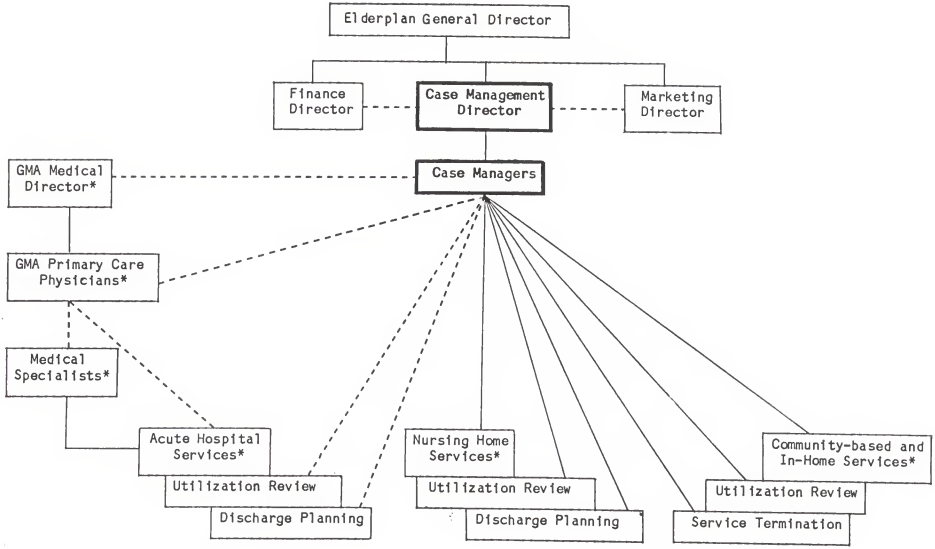


Figure 4

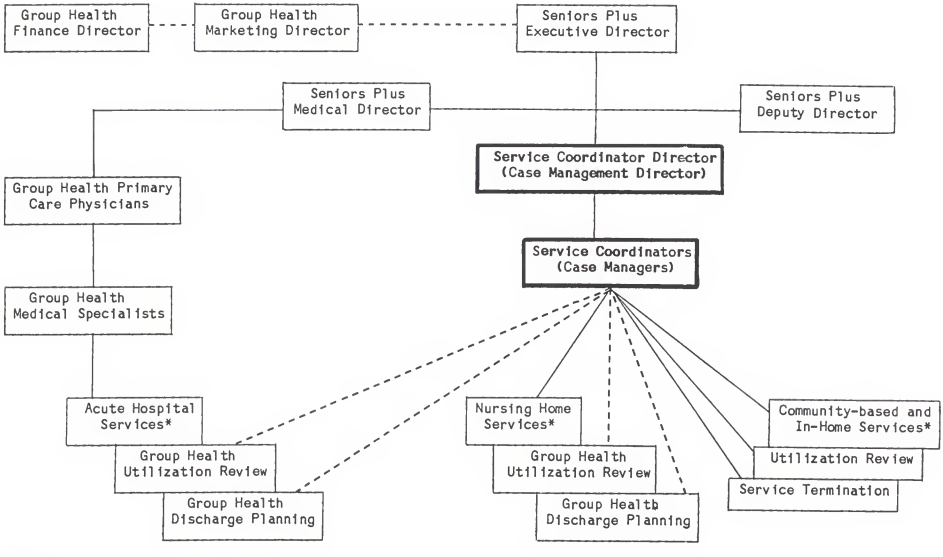
CASE MANAGEMENT LINKAGES WITH THE S/HMO DELIVERY SYSTEM: ELDERPLAN



KEY:
Direct Control _____
Coordination ------
Contracted Services *

Figure 5

CASE MANAGEMENT LINKAGES WITH THE S/HMO DELIVERY SYSTEM: SENIORS PLUS



KEY:
Direct Control _____
Coordination ------
Contracted Services *

Figure 6

CASE MANAGEMENT LINKAGES WITH THE S/HMO DELIVERY SYSTEM: SCAN HEALTH PLAN (SHP)

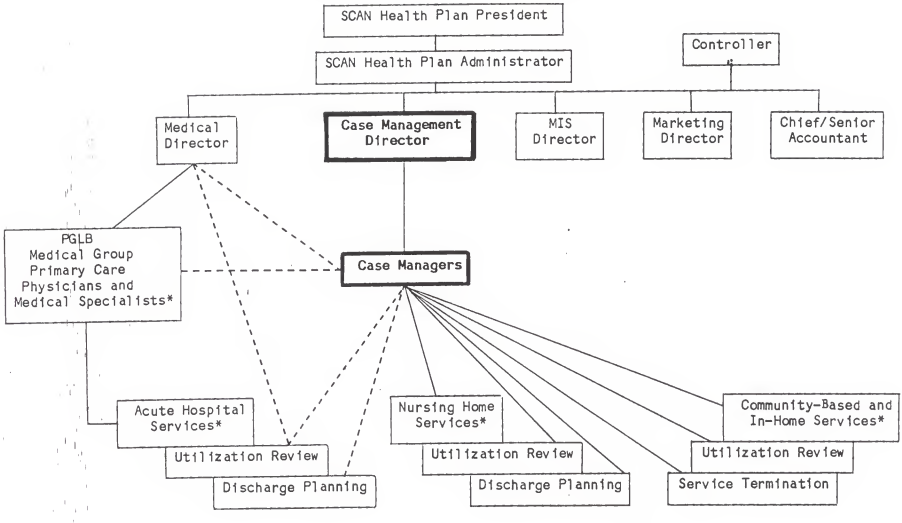


Figure 7

PRIMARY CASE MANAGEMENT ROLES

Roles	Medicare Plus II	Elderplan	Seniors Plus	SCAN Health Plan
Screening/Assessment	Yes	Yes	Yes	Yes
Care Planning and Service Arrangement	Yes	Yes	Yes	Yes
Monitoring Chronic Care Services and Resource Allocation	Yes	Yes	Yes	Yes
Utilization Review				
Hospital	Monitor Only	Yes	Monitor Only	Limited
Nursing Home	Monitor Only	Yes	Monitor Only	Yes
Discharge Planning				
Hospital	No	Yes	No	Limited
Nursing Home	No	Yes	No	Yes
Recordkeeping/Developing MIS	Yes	Yes	Yes	Yes
Other Membership Services	Yes	Yes	Yes	Yes

II, CAFs were completed by a case manager on all new enrollees who HSF data indicated were bedbound or in need of assistance with two or more activities of daily living.

At the three other sites, the CAF was administered by a case manager to any member who was bedbound or unable to perform one or more activities of daily living. In addition, Seniors Plus and SCAN Health Plan, which elected to provide chronic care benefits and/or case management to moderately impaired members, routinely completed a CAF on moderately impaired members prior to implementing services. At all of the sites, the CAF was also administered to members whom a case manager had judged to be in need of services after reviewing specific responses to HSF questions (e.g., a proxy respondent reporting that the member had severe memory loss).

The CAF is a questionnaire covering the client's health conditions, medications, functional impairment, mental status, social interaction, help received from informal caregivers, and current and past service utilization. The CAF is sufficiently detailed to generate the information necessary to meet the different nursing home level-of-care certification requirements of the four sites. After the CAF is completed, the case manager determines eligibility for chronic care services.

Considerable time and money were spent developing and refining the HSF and the CAF. Both instruments had standardized data sets (with optional questions added at each site). These protocols were potentially useful not only for the case managers who used data from these instruments as the basis for care plans, but also for evaluating program outcomes.

Because eligibility criteria for chronic care benefits were not standardized, the demonstrations did not standardize the criteria used to require administration of the CAF. Each site did obtain a baseline CAF on all members who were NHC, all members who had two or more ADL impairments, all members who reported having to stay in bed all or most of the time because of a health problem, and on members receiving chronic care services for reasons beyond the above criteria. Beyond these minimum criteria, CAF data were available on substantially different proportions, and presumably different types, of members at each site.

CARE PLANNING AND SERVICE ARRANGEMENT

After eligibility for services was determined, a case manager developed a plan of care. While not identical, the key components of care planning were similar across sites and included: a) developing problem-oriented care plans with specific objectives, scope, and duration of services; b) exploring care options with the client and the family; c) explaining service costs and copayments to the client and family; d) reinforcing and supporting family caregiving; and e) developing the most cost-effective mix of services within the constraints of the benefit package.

Sites differed somewhat on the procedures used to link the assessment and

care planning processes. At three sites — Elderplan, Seniors Plus, and SHP — each new member assessed as eligible for chronic care services or case management was reviewed at a case conference meeting. A summary of key variables on the CAF was presented, along with the proposed service plan by the assigned case manager. Questions concerning level or intensity of services were resolved at the group meeting, thereby increasing comparability between case managers regarding assessed need and levels of service authorized.

At Medicare Plus II, for the first year and a half of the demonstration, all new cases were presented at case conferences. Subsequently, case managers selected only difficult or problem cases for presentation and discussion. However, all initial care plans had to be approved by the case management director or the lead resource coordinator.

At all sites, the case managers were responsible for coordinating the fairly comprehensive array of institutional and community-based long term care services that constituted the chronic care benefit package. A large portion of each case manager's time was spent making arrangements for chronic care services, including selecting the vendor to provide the service if it was a contracted service and arranging the service days and hours. In addition to arranging for covered chronic care services, at each of the sites the case managers routinely contacted non-S/HMO service providers to obtain information or refer members for services not covered by the S/HMO, such as legal help, social security, shared housing, home delivered meals, friendly visitors, senior centers, etc.

All sites emphasized involving and supporting informal caregivers. Face-to-face meetings or telephone calls were conducted with caregivers to negotiate care plans, explain benefits and copayments, clarify client needs, help the family accept client disabilities, facilitate family interaction, identify tasks family members could reasonably do, and provide support for family caregiving efforts. All sites had written guidelines specifying that no chronic care services could be authorized without first exploring the availability of potential help from informal caregivers.

MONITORING CHRONIC CARE SERVICES AND RESOURCE ALLOCATION

For clients initially receiving community-based services and/or home care, case managers closely monitored needs and services via frequent telephone calls with the client and/or family. In addition, the case managers participated in weekly case conferences during which individual members and their care plans were reviewed. In large part, the case conferences served a quality assurance and utilization review function for chronic care services. Once new services were in place and working well telephone monitoring became less frequent, ranging from once a month to once every three months.

At all sites, clients who were NHC had to be recertified every three months using the state nursing home certification form. The case managers were also required, at six-month intervals, to conduct an in-person formal

reassessment of health, functional status, and service needs for all clients actively receiving chronic care services. This reassessment was a scaled-down version of the Comprehensive Assessment Form with standardized key questions at all sites.

Generally, S/HMO case managers viewed this reassessment process as extra work not essential for monitoring and managing the care of the client. Many case managers felt that frequent contact with the person and/or family provided sufficient information to modify care plans without a formal reassessment. By the end of the second year, Medicare Plus II and SHP were on schedule in conducting reassessments, but Seniors Plus and Elderplan were running far behind schedule.

At each of the sites, one of the primary roles of the case manager was resource allocation — authorizing and overseeing the members' chronic care service use and costs. In most cases this required the development of a long-term chronic care service utilization plan in order to prevent clients from exhausting their benefits.

The sites varied on the maximum annual chronic care benefit: Medicare Plus II offered the greatest coverage ($12,000), followed by SCAN Health Plan ($7,500), Elderplan ($6,500), and Seniors Plus $5,000 annually and $6,500 lifetime for nursing home services. The sites also had somewhat different benefit periods and cost-sharing arrangements (for a detailed discussion of the chronic care benefits and copayments see Chapter 4).

It is important to place in perspective the actual dollars that were available for a case manager to draw on when developing a care plan. An impaired person's S/HMO chronic care budget was not large. For example, at SHP, with a fairly generous $7,500 annual benefit, the average monthly benefit was $625 or $140 per week. If an elderly person with Alzheimer's disease needed day care three days a week at $27 a day and a home health aide to assist the family with the member's personal care needs for two hours at $8.75 per hour on the days when day care was not attended, the weekly cost would be $151, which would exceed the $140 budget. For members with short-term or time-limited chronic care service needs, benefit limits usually posed no problem. For a highly impaired person requiring services on an ongoing basis, services had to be carefully allocated to maximize member benefits.

To date, it appears that the case managers have been able to monitor and maximize benefits with considerable success. For example, during the fourth quarter of 1986, the sites reported that only a small number of members had exhausted their benefits: Medicare Plus II (1 member); Elderplan (4 members); Seniors Plus (7 members); and in SCAN Health Plan, no members exhausted their benefits. For Seniors Plus, which also had the smallest annual chronic care benefit, the proportion of members exhausting their benefits was less than .01 percent. During the fourth quarter of 1985, even fewer members exhausted their benefits.

Although the level of sophistication varied considerably across sites,

each demonstration had developed some mechanism to monitor chronic care service use and costs over time.

Medicare Plus II had a computerized service authorization program, which the case managers used to enter, on a case-by-case basis, data on: the provider (vendor or company from which services were purchased); the type of service provided, beginning and end of the service period, frequency of the service and the number of service units; and the unit costs for each service. The computer then calculated total costs authorized for the service period and year-to-date.

Each case manager was responsible for correcting the authorization forms if the service plan changed or some authorized services were not delivered. The major weakness of this cost monitoring system was that it was not directly linked to the actual billing and payment records. The authorization forms were sent to Kaiser's central billing system and no unauthorized services were paid; however, at the end of the second year of the demonstration there was no systematic procedure for making adjustments for service cost authorized, but unused. Consequently, a member could be entitled to more services than allocated, because the actual services used were less than the services authorized. For example, a case manager might have authorized a home-health aide for three hours, three days a week for a one-month period, but after two weeks, the member's health improved and the aide was no longer needed.

At Elderplan, service authorization forms had not been computerized by the end of the second year. Chronic care services were authorized based on a care plan that was certified and approved for 90 days. Case managers contacted vendors and verbally agreed to the plan of care. The case manager then filled out a separate Authorization for Service form for each service and submitted the form to the case management clerk. A Monthly Service Summary was also completed by the case manager, listing all services and costs, and forwarded to the Finance Department.

Upon receipt of a monthly statement from the vendor, the case management clerk compared the bill with the case manager's service summary. If these documents did not agree, discrepancies were resolved prior to the bill being forwarded to the Finance Department for payment.

Although this system worked, it was cumbersome and time-consuming; each service required a separate authorization form and the case managers had to manually compute costs. The real weakness of the system was that the finance department was also not computerized. At the end of the second year of the demonstration, there was a backlog of unprocessed claims. Since the cross-check between chronic care services authorized and actually billed was also not up to date, case managers could only approximate actual services used and associated costs based on authorized levels of service.

At Seniors Plus, utilization and costs of chronic care services were monitored via a computerized care plan that specified the type of service, the provider, the start date, the review date, the frequency, the unit cost per

service, and the total cost. All authorized services required review at least every six months. Most care plans were reviewed more frequently. There was also a computerized program to make changes in the care plan.

The authorization forms for chronic care services were manually completed by the case managers and the data entered into the computerized care plan by an administrative assistant. The updated care plan was then used by the case manager to identify potential problems. Members whose care plans exceeded $400 per month were flagged for special review, as well as any members who had less than $1,500 left in their chronic care service budget for the benefit year. At Seniors Plus, there was a direct link between service authorizations and paid claims. All vendor bills were entered into the system updating the records to show only those services actually used by a member.

At SCAN Health Plan, chronic care service plans and service authorization forms were computerized. However, all care plans were first hand written and then computerized after the plan had been approved by the case management director. After a plan was approved, the case manager entered the approved services on a computerized Purchase of Service Authorization (PSA) Form. Copies of the PSA were then sent to the member, the vendor from whom the service was purchased, and the SCAN finance department.

If any bill exceeded five percent of the PSA, the accounting department sent the bill to the case management department. It was then the case managers responsibility to review the bill, and make any needed corrections on the computerized PAS.

A second cost check was also built into the SHP system. A case manager could write a PSA for an amount higher than specified in the plan, but the PSA was held in the computer until the case management director authorized the PSA, using a special (high-cost) PSA authorization program, which only the case management director could access.

UTILIZATION REVIEW

Utilization review for S/HMO clients who were hospitalized or placed in a nursing home, was one of the functions for which case manager responsibilities varied considerably among the four sites.

In Medicare Plus II, the S/HMO case managers were not responsible for hospital utilization review. This role was performed by the Kaiser utilization review teams, who performed this function at the two Kaiser-owned hospitals in Portland. Case managers were also not responsible for nursing home utilization review. This function was performed for S/HMO clients by the SNF review coordinator who did SNF utilization review for all Kaiser patients placed in contracted homes throughout the service area. The S/HMO case managers coordinated as needed with the Kaiser hospital and nursing home utilization review teams. While no problems were reported with these arrangements for utilization review, there was little evidence of close working relationships between the two groups of professionals.

At Seniors Plus, as at Medicare Plus II, the case managers were not directly responsible for either hospital or SNF utilization review. Hospital utilization review for S/HMO clients in Seniors Plus was performed by the Group Health, Inc. utilization review staff, who performed this function for all Group Health members admitted to contracted hospitals. For each hospital patient, review staff visited the hospital to review the chart for the overall appropriateness of care and length of stay; determined if services could be provided in a less intensive setting; and assessed the quality of care provided.

When the utilization review coordinators found a Seniors Plus "marker" on the patient's medical record, they routinely checked with the S/HMO case management department to determine if the person had an assigned case manager and then obtained additional information about the client. The care plan and discharge plan were also closely coordinated with the S/HMO case manager.

SNF utilization of S/HMO members was reviewed by a geriatric nurse practitioner who performed this role for all elderly in the Group Health plan, but who had a special interest in the S/HMO concept and worked closely with the S/HMO case managers. The nurse practitioner attended the initial case conference in the contracted nursing homes and consulted in the authorization of services. Ongoing utilization review was primarily for quality assurance purposes, but chronic care benefit coverage was also monitored.

At Elderplan, one case manager (an RN) was designated as the S/HMO utilization review coordinator. With respect to hospital utilization review, the case manager was given responsibility for authorizing each S/HMO patient's expected length of stay based on the PAS geriatric and then communicating the expected length of stay to all the involved disciplines.

This proved to be a formidable task for several reasons: only contracted medical specialists had admitting privileges at the principal hospital used by S/HMO patients (i.e., Maimonides Medical Center); the S/HMO primary care physicians did not have admitting privileges at the hospital (until the third year of the demonstration) but were able to monitor S/HMO patients in the hospital; and there were numerous interns providing routine care on the hospital floor at the principal hospital. In addition, Elderplan had contracts with two other hospitals, which the case manager had also to visit in order to monitor S/HMO patients. At both these hospitals, the S/HMO primary care physicians had admitting privileges, so coordination was greatly facilitated.

At Elderplan, the case management utilization review coordinator was also responsible for SNF utilization review in the nursing homes run by the S/HMO sponsor, Metropolitan Jewish Geriatric Center. All nursing home patient charts were reviewed once a week. The primary purpose of the ongoing review process was to reassess the potential for home care. Unlike the hospital utilization review, the nursing home utilization review caused the site no reported problems.

Utilization review for hospital patients in SCAN Health Plan was done by the SCAN medical director. Once a month, the medical director met with 10-15 physicians in the contracted medical group to discuss utilization data and conduct a review of all S/HMO cases with higher than average utilization rates. In addition, the medical director received a list each day of all hospitalized SHP members and if any problems arose, the chart was reviewed with the primary care physician. An RN case manager also performed utilization review for "planned elective" admissions. This case manager also prepared post-acute care plans for these admissions. Finally, both the medical director and director of case management were members of the hospital quality assurance board, which met monthly.

Nursing home utilization review for SCAN Health Plan was the responsibility of one case manager (an RN) who attended a weekly team conference at the primary SNF. The case manager reviewed S/HMO member care plans and encouraged nursing home staff to consider potential for discharge to home care. The case manager's role as the SNF utilization reviewer included both quality assurance and cost control reviews.

DISCHARGE PLANNING

Like utilization review, discharge planning was another function in which the roles and responsibilities of the case managers differed substantially across the demonstration sites. S/HMO members at all sites were entitled to SNF/ICF and home-care services traditionally provided under Medicare guidelines. The chronic care benefit supplemented services traditionally available.

Hospital discharge planning for S/HMO clients was not the responsibility of the S/HMO case managers at Medicare Plus II. The case managers received a list from two Kaiser-owned hospitals with the names of all S/HMO clients admitted to each hospital. The Kaiser discharge planners called the case managers if they thought the person was qualified for S/HMO chronic care benefits.

At Medicare Plus II, hospitalized members were generally not formally assessed with the CAF while still in the hospital. They were, however, assessed for nursing home certification by one of the case managers. If the member qualified, a care plan was jointly developed by the discharge planner and the case manager. If, at the time of discharge, the member qualified for either nursing home or home care under traditional Medicare criteria, the chronic care benefit was not activated, and the Kaiser discharge planner assumed responsibility for the care plan and follow-up.

SNF discharge planning for S/HMO clients was generally not the case manager's responsibility at Medicare Plus II. Limited discharge planning was performed by the Kaiser SNF Review Coordinator, but primary responsibility for discharge planning belonged to each contracted SNF facility. If the patient appeared to be eligible for chronic care benefits, discharge planning was

coordinated with the S/HMO case managers. No problems were reported by Medicare Plus II with these arrangements for discharge planning for S/HMO clients in hospitals or nursing homes.

At Seniors Plus, all hospital discharge planning for S/HMO clients was done by Group Health Continuing Care/Discharge Planners who performed this function for all Group Health members. The primary role of the discharge planner was to facilitate patient discharges from the contracted hospitals.

For S/HMO members, the discharge planners reported having more options with respect to coverage for nursing home care and home-care services, often making early discharge possible. The discharge planners reported working closely with the S/HMO case managers to ensure that follow-up services were in place at the time of discharge.

SNF discharge planning at Seniors Plus was done by the geriatric nurse practitioner who was in charge of nursing home management for all Group Health members. The geriatric nurse practitioner worked closely with the S/HMO case managers, the client, and the family throughout the client's nursing home stay and at the time of discharge. In general, the goal was to discharge members to their homes with long term care services if feasible. The nurse practitioner reported that the chronic care benefits made it much easier to return S/HMO members to their homes (than elderly Group Health members who were not S/HMO members) because the needed services would be covered under the chronic care benefit.

In contrast to Medicare Plus II and Seniors Plus, Elderplan found hospital discharge planning to be quite problematic. The case manager who handled hospital utilization review was also responsible for discharge planning. Essentially, the case manager had the responsibility, but did not actually have the authority, to control discharge planning.

Because the S/HMO primary care physicians did not have admitting privileges at the hospital of choice for most S/HMO members (Maimonides Medical Center), at best, the case manager "facilitated" discharge planning (e.g., encouraged timely discharge, arranged transportation, and made sure community or home services were in place). At Maimonides, the case manager role was also a source of contention with the regular hospital utilization review and discharge planning staff, who felt the job could be done more efficiently and effectively in-house. By contrast, at Lutheran Medical Center, where a small number of S/HMO members had been placed, discharge planning by the S/HMO case manager was operating smoothly. The S/HMO primary care physicians had admitting privileges. They coordinated their work with the case manager, and the regular hospital discharge planner reported that S/HMO patients seemed to be discharged faster than non-S/HMO patients, primarily because coverage for in-home services and SNFs was available.

At SCAN Health Plan, in 1986, hospital discharge planning for all elective surgeries and planned admissions was the responsibility of one RN case manager who visited the member in the hospital and determined if chronic

care services were needed. For members requiring only short-term services, the case manager was able to authorize chronic care services for up to 30 days.

The other sites also provided chronic care benefits to post-hospital members, but only for short periods of time. SHP was the only site that specifically designated one care manager as responsible for members requiring short-term chronic care services. When an SHP member was going to require chronic care services for longer than 30 days, the case was sent to the case management department and assigned to another case manager.

Discharge planning for all other S/HMO hospital admissions was performed by the discharge planners at the contracted S/HMO hospitals. Using chart notes rather than direct communication reportedly caused delays in contacting case management staff and obtaining authorizations for services, espécially in-home services. New procedures were being developed at the end of the second year of the demonstration.

Regardless of whether S/HMO case managers or hospital discharge planners arranged for discharge, SHP had some problems similar to those faced by Elderplan. Traditionally, at the hospital, physicians were reportedly not "pushed" to discharge early. The S/HMO medical director had been working with the contracted primary care physicians and specialists attempting to reduce length of stay, but it appeared little progress had been made in reducing hospital lengths of stay.

The S/HMO case manager who worked with hospital discharge planners also performed all nursing home discharge planning for S/HMO members, even if the members were not being case managed or sent home with chronic care services. The case manager attended a weekly team conference at the contracted SNF and reported that SNF staff had started viewing S/HMO clients from a management perspective -- setting up goals, and listing them in care plans. No problems were reported with nursing home discharge planning.

For a more detailed discussion of organizational factors influencing hospital and nursing home utilization, see Attachment A.

RECORD KEEPING AND DEVELOPING AN MIS

At each of the demonstration sites, there was extensive record keeping and all sites were in the process of developing computerized Management Information Systems (MIS) to assist case managers.

At Medicare Plus II and SCAN, one of the case managers had been specifically assigned to oversee the MIS to make it workable for the case management department. In 1986, each site kept the following minimum records on members receiving chronic care services:

- Health Status Form (HSF);
- Comprehensive Assessment Form (CAF);

- Nursing Home Certification (NHC) Form;
- Care Plan;
- Service Authorization Form;
- Change in Care Plans or Service Authorization;
- Physician Referral Form; and
- Progress Notes.

Beyond this, each site developed a variety of different forms to help monitor and track a member. The extent to which the systems were computerized varied by site. All sites computerized the HSF. With the exception of Elderplan, all sites computerized the service authorization form. SCAN Health Plan, Medicare Plus II, and Seniors Plus had also computerized some tracking/reporting forms by the end of the second year of the demonstration.

OTHER MEMBERSHIP SERVICES

Initially, the case management department at each of the sites was actively involved in public relations activities such as making presentations to seniors and service provider groups about the S/HMO. As enrollment increased, the case managers became less involved in public relations, but at all sites they continued to be intermittently involved in member-related activities such as making presentations, handling special inquiries about the chronic care benefit, and following up minor complaints and grievances.

CASE MANAGEMENT DEPARTMENT STAFFING PATTERNS

To date, there are no established standards for the professional qualifications of a case manager in the health care field. The case management staffing patterns across all sites were multidisciplinary and included a combination of social workers, nurses, and therapists. The majority of the staff held master's degrees, and many had degrees in gerontology. Many case managers had extensive experience in long term care settings, thereby bringing a high level of professional training as well as relevant work experience to the demonstrations. Most case managers viewed their positions as challenging and on the cutting edge of change in health care for the elderly.

The major staffing differences among the four S/HMO case management departments were the number of staff and the specific roles and responsibilities assigned to the case managers. This section summarizes information on the number of staff, their primary activities, and client caseloads. Attachment B provides more detailed information about the case management staffing patterns at each site including: position titles, professional qualifications, full-time equivalency of each position, and specialized functions by staff members. Table 3 summarizes the staff allocation and time by three primary activities (administrative matters, client case management services, and utilization review/discharge planning) and shows the average caseload per full-time equivalent (FTE) case manager at the end of the second year of the demonstration.

Table 3

ALLOCATION OF CASE MANAGEMENT STAFF TIME BY FUNCTIONS

	FTE	Average Caseload Fourth Quarter 1986[a]
Medicare Plus II		
Administrative Matters	1.55	N/A[b]
Client Case Management	4.50	70
Utilization Review/Discharge Planning	0	N/A
Total FTE	6.05	N/A
Elderplan		
Administrative Matters	3.0	N/A
Client Case Management	3.0	45
Utilization Review/Discharge Planning	1.0	N/A
Total FTE	7.0	N/A
Seniors Plus		
Administrative Matters	2.0	N/A
Client Case Management	2.5	100
Utilization Review/Discharge Planning	0	N/A
Total FTE	4.5	N/A
SCAN Health Plan		
Administrative Matters	3.75	N/A
Client Case Management	5.2	80
Utilization Review/Discharge Planning	.5	N/A
Therapist	.5	N/A
Total FTE	9.95	N/A

[a] Average caseload per full time equivalent case manager.

[b] N/A indicates information was not available.

At Medicare Plus II, the case management department was headed by an experienced speech pathologist from within the Kaiser system. The case management administrator was assisted by two lead resource coordinators (an RN and an ACSW), four additional resource coordinators, and one clerical staff member. In total, the case management department had 4.5 full-time equivalent (FTE) case managers. The average active caseload per FTE case manager was 30 to 35 active ongoing clients with an additional 30 to 35 clients on a less intensive follow-up basis.

At Elderplan, the case management department was headed by an ACSW with considerable experience in community-based long term care. The case management director resigned in late 1986 and a new director came on board in March 1987. The department staff included a utilization review coordinator (an RN), three case managers (an RN and two MSWs), a systems coordinator who processed service authorization forms and other data, and one clerical staff member. In total, the case management department had three FTE case managers with an active caseload of 35 clients each and with five to ten additional cases monitored less intensively.

The service coordinator and director of case management at Seniors Plus held an MSW degree. (The director resigned in the summer of 1986, and the position was filled by another MSW.) The director was assisted by two full-time case managers (an RN and a BSW), a full-time administrative assistant who maintained the service utilization/claims system for long term care services, and a part-time secretary. In total, the service coordination unit had 2.5 FTE staff who provided client case management services. The active caseload per FTE case manager was 65 to 70 cases with an additional 25 to 30 cases monitored less intensively.

Of the four demonstrations, the SCAN Health Plan had the largest case management staff. The case management department was managed by an MSW/ACSW with considerable experience in community-based care for the elderly. She was assisted by a case management nurse supervisor, 4.7 FTE case managers (with MSW/MSG, MSW, BSW degrees), and a half-time RN who was responsible for discharge planning for elective surgery and who planned hospital admissions as well as discharge planning for all nursing home patients. A half-time physical therapist assessed the need for therapy and provided services when needed. The other two staff members provided clerical/secretarial support services. Half of one of the case manager's time was also allocated to monitoring the case management department's Management Information system (MIS). In total, the case management department had 5.2 FTE staff providing direct client case management services. The average client caseload was 80 cases per full-time equivalent case manager, about 50 cases actively receiving services and 30 less active but monitored at least once a month.

There were three principal differences in the case management staffing patterns of the sites:

- At Elderplan and SCAN Health Plan, a case manager was responsible for hospital and nursing home utilization review and discharge planning

activities; at Medicare Plus II and Seniors Plus, these activities were not assigned to S/HMO case managers.

- Elderplan and SCAN Health Plan had a larger number of administrative/support staff to carry out case management-related functions.

- There were differences in the actual number of staff and average caseload per case manager. With the exception of Elderplan, the differences found in staffing size and caseload tended to reflect differences observed in the member population eligible for chronic care benefits and/or case management services.

The Medicare Plus II program in Portland carefully restricted the chronic care benefit and case management services to members certified as nursing home eligible. The average caseload per FTE case manager was 70 cases. On the other hand, in Elderplan, where chronic care benefits and case management were provided to NHC clients as well as those at risk of nursing home placement, the average caseload per FTE case manager was 45 cases. As expected, in the other two sites, where chronic care benefits and case management were provided to nursing home certifiable clients as well as those needing preventive services, the caseloads were somewhat higher. At SHP, the average caseload per FTE case manager was 80 cases; at Seniors Plus, 100 cases.

CASE MANAGEMENT COSTS

Table 4 presents the cost per member per month (pmpm) for case management — that is, the monthly cost to the plan for the case management component. (This cost estimate is different from the average monthly cost of case management for individuals actually receiving the service.) Cross-site pmpm comparisons must be interpreted with some caution because the S/HMOs varied considerably with respect to administrative, clerical, and other support staff time allocated to case management costs. In addition, at the two sites affiliated with existing HMOs (Medicare Plus II and Seniors Plus), the case management cost reported did not include the cost associated with services such as utilization review and discharge planning performed for S/HMO clients by HMO personnel. Subsequent analyses will adjust for these and other identified differences in case management cost across sites.

At three of the sites, the cost of case management per member declined during year two of the demonstration. In 1986, the two sites with the lowest case management cost were Medicare Plus II ($4.50) and Seniors Plus ($9.17) — the two sites affiliated with existing HMOs. The somewhat higher cost at Seniors Plus was a reflection of the larger proportion of the membership provided with case management services — approximately 19 percent, compared to 8 percent at Medicare Plus II.

In 1986, SCAN Health Plan had the highest case management cost ($15.37 pmpm), in part explained by the high proportion of users (20%), but also due to the inclusion of personnel not included in the case management budget at other sites (e.g., a physical therapist, a data clerk, and a utilization

Table 4

CASE MANAGEMENT COSTS IN 1985 AND 1986

Site	1985 Costs PMPM[a]	Percent of Total Budget	1986 Costs PMPM[a]	Percent of Total Budget
Medicare Plus II	$ 4.50	1.7[b]	$ 4.50	1.6[b]
Elderplan	23.91	3.5%	9.92	2.2%
Seniors Plus	39.27	9.3	9.17	3.2
SCAN Health Plan	22.20	4.3	15.37	3.9

Source: S/HMO Demonstration Quarterly Reports, 1985, 1986. Note: These are unaudited data from the Quaterly Reports. Not all claims were submitted when these reports were prepared in November 1987.

[a] Average costs per member per month.
[b] The Medicare Plus II costs were based on the average adjusted community rate for case management during 1985 and 1986. Actual case management costs reached $6.75 pmpm by the end of 1986.

review/discharge planning case manager). Elderplan case management costs were difficult to interpret. Relative to the other sites, Elderplan provided case management services to the smallest proportion of its membership (6%). Yet, at Elderplan in 1986 the case management cost per member per month ($9.92) was slightly higher than at Seniors Plus, which provided case management to 19 percent of its membership. The relatively high case management costs can be explained, in part, by the inclusion of hospital discharge planning and utilization review activities under case management.

DISCUSSION

Two distinct patterns that emerged in the S/HMOs have potentially important implications for case management and other client and cost outcomes.

- The target population and eligibility criteria for chronic care services differed. Two sites restricted access to chronic care services to members who were highly impaired. One of the sites was affiliated with an existing HMO; the other was a newly created HMO. The other two sites elected to expand eligibility criteria and provide chronic care services to highly impaired as well as moderately impaired members, in order to test the impact of preventive care. One of these sites was affiliated with an existing HMO, the other was a newly created HMO.

- The roles of the case managers were influenced by the organizational structure. The two sites affiliated with existing HMOs chose to leave primary responsibility and control over acute care utilization with existing HMO health professionals. The two sites that created newly formed HMOs attempted to gain control over acute care utilization by assigning part of the utilization review and discharge planning responsibilities to the case management component of the S/HMOs.

By the end of the second year of the demonstration, there was considerable variation among the sites regarding the extent to which the acute and long term care services had been integrated to provide an effectively coordinated continuum of care for the impaired elderly.

In general, at Medicare Plus II, S/HMO case management was a fairly insular unit functioning with a reasonable, although not a strong, degree of coordination within the larger Kaiser system. Most physicians and providers generally did not know whether a member was in the Medicare Plus II program. The larger Kaiser system remained responsible for acute hospital care, medical care, and Medicare-covered home or nursing home care. The S/HMO case managers were only responsible for the expanded chronic care services and budget.

At Elderplan, there was little evidence of an integrated service system. It appeared that the S/HMO could have benefited from stronger ties and coordination between the medical/hospital service components and the case management component responsible for long term care. A large number of medical specialists operating independently of the S/HMO were responsible for acute hospital care. The primary care physician group was under contract to

the S/HMO but was not closely linked to the case management component. In an attempt to gain control over hospital utilization, a case manager was assigned the utilization review and discharge planning functions, but did not have the power or authority to influence practice patterns. Further, working relationships between key actors in the principal acute care hospital and the case managers were not strong. Long term institutional and inhome care were the sole responsibility of the case managers, with little input from the medical component.

In contrast to Elderplan, Seniors Plus appeared to effectively integrate the S/HMO case management department with two strong preexisting service providers -- Group Health, Inc. and Ebenezer Society. At each level of health care -- acute hospital, outpatient clinic, nursing home, community-based services, and in-home services, there were well-defined, closely coordinated working relationships between the case managers and the other service providers. In turn, the other service providers recognized that when a S/HMO client required chronic care services, the case managers then had control over chronic care service use and cost. Continued coordination between the acute care and long term care service teams was evidenced in the case conference meetings attended by the medical director, select physicians, the home-care service director from Ebenezer, the geriatric nurse practitioner who managed nursing home care, and the S/HMO case managers.

In the SCAN Health Plan, a large number of health care providers were potentially involved in the member plan of care. Even though the SCAN program had a number of years of experience working with many of the providers in the MSSP program, the S/HMO case management department faced a tremendous challenge as it attempted to coordinate this diverse group of service providers into a comprehensive continuum of care for the impaired S/HMO members. Each type of health care was provided by a different contracted vendor. With the assistance of the SCAN Health Plan medical director, the role of the case management department was to coordinate this array of service providers. At the end of second year of the demonstration, it appeared that some of the linkages needed to be strengthened and better coordinated -- especially between the S/HMO case managers and the primary care physicians, the medical specialists, and the hospital discharge planning unit. It was also unclear whether the quality of care being provided by the numerous service vendors was being sufficiently monitored.

RECOMMENDATIONS FOR FURTHER RESEARCH

This preliminary review of the case management component of the S/HMO demonstration has identified a number of issues and questions to be examined in subsequent analyses.

- What would be the impact on client case-mix and program revenues if the NHC criteria, found to be substantially different across sites, were standardized?

- Could the queuing mechanism be revised to better assist the plans in

obtaining an appropriate case-mix?

- Will the case managers be able to continue to stay within chronic care budgets as the membership ages and potentially develops increased long term care service needs?

- Are the systems developed to authorize and monitor chronic care service use and costs adequate? To what extent are the case manager authorizations (and therefore their working budgets) under or over actual paid claims for individual members?

- What is the extent to which families are supplementing the chronic care benefit package with their informal caregiving services? How do case managers influence caregiver involvement?

- To what extent are individuals and their families supplementing the chronic care benefits with other long term care services paid for out of pocket?

- Is it important for reasons of continuity of care and/or cost containment to have case managers involved in hospital utilization review and discharge planning? The preliminary findings suggest these may not be pivotal roles for case managers.

- What is the impact of a site having multiple contracted vendor agencies, in terms of case manager work load and member satisfaction with services?

- Will the case managers to able to develop chronic care norms of practice and protocols for issues such as normal usage, equity of service allocation, and quality of care? These norms of practice are being developed informally through the case conferences, but it would be a major accomplishment if the demonstration could develop written standards, guidelines, and procedures for chronic care service delivery.

- What are the similarities and differences between case management in the S/HMOs and case management as practiced in the earlier long term care demonstrations?

- Finally, what aspects of the S/HMO case management approach show the greatest potential for useful replication in prepaid health care settings?

SUMMARY FINDINGS

- In the S/HMO, the role and authority of the case manager was envisioned as much broader than the case manager role in earlier long term care demonstrations. In early demonstrations (e.g., Connecticut's Triage I and II, Georgia's Alternative Health Services Project, and California's Multipurpose Senior Services Project), the case manager role focused primarily on screening/assessment and the coordination and/or provision

of community-based care. In the S/HMO, the case manager was to have primary responsibility for authorizing all long term care services, responsibility for monitoring the chronic care services and budget, and final authority over chronic care resource allocation.

- There were no restrictions placed on the S/HMO demonstrations concerning which members should be eligible to receive the expanded long-term care benefits. One of the primary reasons for giving the demonstrations latitude in defining eligibility for the chronic care benefit was to see how services could best be targeted to impaired elderly, working within tight budget constraints.

- Because each site was reimbursed at a higher capitated rate for any S/HMO member who was assessed as meeting the state nursing home certification (NHC) criteria, it was decided to link eligibility for the chronic care services, at least in part, to NHC status.

- In general, a review of the criteria variables and their definitions showed nursing home certification criteria to be the most stringent in Medicare Plus II followed by Elderplan, Seniors Plus, and SCAN Health Plan (SHP). Although each site paralleled its state NHC form and guidelines to qualify a member for chronic care benefits (and a higher reimbursement rate), the NHC criteria were not identical across the four demonstrations.

- Beyond the NHC criteria, each site chose to expand its eligibility criteria and provide at least some services to members who were not nursing home certifiable. Thus, the membership eligible to receive chronic care services and/or case management was determined by interrelated factors: the stringency of the state NHC criteria and the site's application of these criteria; the extent to which the site permitted provision of chronic care services to less impaired members; and the extent to which the site provided case management services to members who did not qualify for chronic care services.

- The four demonstrations can be placed on a continuum ranging from the most restrictive to the least restrictive eligibility criteria for the chronic care benefits and/or case management services. Medicare Plus II was the most restrictive, followed by Elderplan. Seniors Plus and SCAN Health Plan were substantially less restrictive.

- Because uncertainty about biased selection was a major issue in the S/HMO, the sites were given the option of queuing. The purpose of the queuing process was to maintain a case-mix in the S/HMO population with distributions on levels of functional impairment representative of the distributions estimated for persons 65 years of age and over in the community. Only three of the sites chose to use queuing -- Elderplan, Seniors Plus, and SCAN Health Plan. Medicare Plus II elected not to queue preferring to obtain a balanced case-mix through effective marketing.

- Differences in NHC eligibility criteria, as well as site decisions about providing services to non-NHC members, explains the different proportions of total membership permitted access to chronic services: Medicare Plus II, 4.9 percent; Elderplan, 2.9 percent; Seniors Plus, 11.0 percent; and SCAN, 12.1 percent.

- There was considerable variability between sites, as well as within a site over time, in the proportion of the membership that was NHC (4.1-7.2%), as well as the proportion of the membership receiving chronic care services (2.9-12.1%) or case management services only (2.6-8.2%).

- In developing the S/HMOs, considerable effort, time, and money were spent developing and refining assessment instruments, the Health Status Form (HSF) and the Comprehensive Assessment Form (CAF). In both instruments, there was a standardized data set (with optional questions added at each site). These protocols were potentially useful not only for the case managers who used data from these instruments as the basis on which care plans were made, but also for evaluating program outcomes.

- While not identical, the key components of care planning were similar across sites including: a) developing problem-oriented care plans with specific objectives, scope, and duration of services; b) exploring care options with the client and the family; c) explaining service costs and copayments to the client and family; d) reinforcing and supporting family caregiving; and e) developing the most cost-effective mix of services within the constraints of the benefit package.

- Importantly, all sites had written guidelines specifying that no chronic care services could be authorized without first exploring the availability of potential help from informal caregivers.

- Although written quality assurance guidelines for chronic care services had not been developed at any site, the case conferences served a quality assurance and utilization review function for chronic care services.

- Generally, the reassessment process (i.e., in-person administration of a Reassessment Form at six-month intervals) was not viewed as essential for the ongoing monitoring and management of the client. The reassessment instrument was viewed primarily as a research tool. Many case managers felt that frequent contact with the person and/or family provided sufficient information to modify care plans without a formal reassessment.

- The funds available for a case manager to draw on when developing a chronic care plan were not large. For members with short-term or time-limited chronic care service needs, the benefit limits usually posed no problem. For a highly impaired person requiring services on an ongoing basis, services had to be carefully allocated to maximize the member's chronic care benefit.

- At each of the demonstration sites there was extensive record keeping for use and expenditures for chronic care servicees. All sites were in the process of developing computerized Management Information Systems (MIS) to assist the case managers in monitoring and tracking client services and costs. At two of the sites — Medicare Plus II and SCAN — one of the case managers had been specifically assigned to oversee and work with the MIS to make it useful and workable for the case management department.

- The majority of the case management staff held master's degrees and a number of case managers had gerontology degrees.

- There were three principal differences among the case management staffing patterns at the sites:

  - At Elderplan and SCAN Health Plan, a case manager was responsible for hospital and nursing home utilization review and discharge planning activities; at Medicare Plus II and Seniors Plus, the two sites affiliated with existing HMOs, these activities were not assigned to S/HMO case managers.

  - The two sites not affiliated with existing HMOs (Elderplan and SCAN Health Plan) had a larger number of administrative/support staff to carry out case management related functions.

  - There were differences in the actual number of staff and average caseload per case manager. With the exception of Elderplan, the differences found in staffing size and caseload reflected differences observed in the member population eligible for chronic care benefits and/or case management services.

- At each of the sites, the cost of case management per member declined during year two of the demonstration. In 1986, the two sites with the lowest case management cost were the two sites affiliated with existing HMOs — Medicare Plus II and Seniors Plus.

- At the end of the second year of the demonstration, there was considerable variation among the sites regarding the extent to which the acute and long-term services had been integrated to provide an effectively coordinated continuum of care for impaired elderly.

  In general, at Medicare Plus II, S/HMO case management was a fairly insular unit functioning with reasonable, although not strong, coordination within the larger Kaiser system. At Elderplan, there was little evidence of an integrated service system. It appeared that the S/HMO could have benefited from stronger ties and coordination between the medical/hospital service components and the case management component responsible for long term care. By contrast, Seniors Plus appeared to have effectively integrated the S/HMO case management department with

two strong preexisting service providers -- Group Health Incorporated and Ebenezer Society. In the SCAN Health Plan, a large number of health care providers were potentially involved in a member plan of care; each type of health care was provided by a different contracted vendor. The case management staff faced a tremendous challenge as they attempted to coordinate this diverse group of service providers into a comprehensive continuum of care for the impaired S/HMO members.

- Two distinct patterns have emerged in the S/HMOs with potentially important implications for case management and other client and cost outcomes related to the S/HMO chronic care services benefits:

  - The target population and eligibility criteria for chronic care services differed. Two sites restricted access to chronic care services to members who were highly impaired. One of the sites was affiliated with an existing HMO; the other site was a newly created HMO.

    The other two sites elected to expand eligibility criteria and provide chronic care services to highly impaired as well as moderately impaired members, in order to test the impact of preventive care. One of these sites was affiliated with an existing HMO; the other site was a newly created HMO.

  - The roles of the case managers were influenced by the organizational structure. The two sites affiliated with existing HMOs chose to leave primary responsibility and control over acute care utilization with existing HMO health professionals. The two sites with newly formed HMOs attempted to gain control over acute care utilization by assigning part of the utilization review and discharge planning responsibilities to the case management component of the S/HMO.

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ATTACHMENT A

CASE MANAGEMENT LINKAGES WITH THE S/HMO DELIVERY SYSTEM

One of the major goals of the S/HMO demonstration was to create a truly integrated service system for the elderly. The challenge in organizing the S/HMO service delivery system was to find a workable balance between the need for autonomy on the part of the various service providers and professionals and the need for better coordination where services were interdependent. In some instances, this could require redefining traditional roles. This attachment describes the strengths and the weaknesses of the linkages developed between the case management component of the S/HMOs and the larger S/HMO health care delivery systems at the end of the second year of the demonstration.

MARKETING AND FINANCE DEPARTMENTS

Each site had marketing and finance departments, but the case management department had very little involvement with these two components of the system. There were three exceptions. At Elderplan, case managers were responsible for collecting chronic care copayments; at SCAN Health Plan, the case management director worked closely with the finance department, establishing rates and developing contracts for the chronic care vendors. The director and several case managers at SHP also continued to remain active with marketing, making frequent presentations about the S/HMO. In the early months of the demonstration, case managers at all sites were actively involved in marketing the S/HMO.

MEDICAL DIRECTOR

Each of the sites had a S/HMO medical director or advisor, but generally the amount of time allocated for the director (half-time or less) precluded substantial involvement with the case management department. At Medicare Plus II, the demonstration had a medical consultant who was a Kaiser internist. In addition, during year two, a geriatrician internist served as a clinical consultant to the S/HMO project. The internist attended case management meetings and served as a liaison with the other physicians. (This internist left Kaiser in the fall of 1986 and the position had not been refilled at the end of year two.)

Elderplan contracted for a medical director through its physician group, Geriatric Medicine Associates (GMA). At the end of the second year of the demonstration, the medical director was full-time. The case management department did not work closely with the medical director, although some coordination usually occurred when a S/HMO member was referred for chronic care services.

At Seniors Plus, the medical director was a geriatrician who was no longer with Group Health, but remained with Seniors Plus as a consultant (.10 FTE). Although his time was limited, the case management department viewed

him as a valuable resource. He frequently attended case conferences and advised on the medical treatment and management for clients receiving chronic care benefits. Second, the medical director served as a liaison between the case managers, primary care physicians, and medical specialists, if the case managers had problems or questions related to the medical management of a client.

At SCAN Health Plan, at the end of year two, there was a half-time medical director from the contracted physicians group. His primary role was to perform hospital utilization and quality assurance reviews. Although the medical director was not extensively involved with the case management department, he attended case conferences and provided direct feedback and medical advice about individual clients.

PRIMARY CARE PHYSICIANS

At Medicare Plus II, there were approximately 350 different physicians in the medical group. There was little direct involvement between the primary care physicians and the case managers. The S/HMO case managers tended to coordinate, when necessary, with one or two physicians at 10 of the 11 outpatient clinics. As a general rule, the S/HMO case managers encouraged family members or clients to take responsibility for medical care and interaction with the physicians.

At Elderplan, primary care physicians were contracted from a small group of geriatricians who formed Geriatric Medicine Associates (GMA) and only served S/HMO members. The group experienced high physician turnover, and during most of the first two years of the demonstration, there were only 1.5 to 2.5 FTE physicians. Initially, when enrollment was low, the physicians attended case management conferences, but that practice was abandoned as membership grew. There was only limited involvement between the case managers and the primary care physicians. Coordination occurred primarily through the nurse coordinator at the GMA office who arranged appointments for impaired S/HMO clients.

At Seniors Plus, there appeared to be closer coordination among the case managers and the primary care physicians than at the other sites. In part, this may be explained by the way Group Health staffed its outpatient clinics. At each of the 14 Group Health clinics, there tended to be one or two physicians who were geriatricians or interested in geriatric care, and they were the physicians with whom the case managers worked. The case managers took referrals from the physicians and also called the physicians when medical questions arose. On request, the primary care physicians also attended the case management conferences.

At SCAN Health Plan, primary care physicians were contracted from an IPA medical group, the Physician Group of Long Beach (PGLB). Many of these physicians were not strongly committed to the S/HMO, and there were a number of resultant problems. There was not a strong link between the case management department and the physician group. The S/HMO medical director was

the principal link between the case management department and the primary care physicians. However, case managers did have phone consultations with individual physicians.

MEDICAL SPECIALISTS

At all of the sites, the case managers had only limited involvement with the medical specialists. At the two sites affiliated with existing HMOs (Medicare Plus II and Seniors Plus), the medical specialists were part of the larger HMO. In general, case managers had little involvement with the specialists, but communicated as needed. Elderplan contracted with a number of independent medical specialists. It was the responsibility of the GMA primary care physicians to coordinate with the medical specialists. The case managers of SCAN Health Plan had little contact with the medical specialists; coordination was handled through the SHP medical director.

ACUTE HOSPITAL SERVICES

At Medicare Plus II, Kaiser primary care physicians and medical specialists admitted S/HMO clients to one of two Kaiser-owned hospitals in the catchment area. Kaiser staff performed all utilization review and discharge planning functions for hospitalized S/HMO clients. Clients potentially eligible for chronic care services were referred to the S/HMO case managers for an assessment and determination of eligibility for expanded benefits. In general, no problems were reported, but there was also no evidence of any special coordination efforts between Kaiser acute hospital staff and the S/HMO case managers. Essentially, the hospital staff treated S/HMO members like any other Kaiser member.

At Elderplan, hospital services were provided in three contracted community hospitals. One S/HMO case manager was responsible for all hospital utilization review and discharge planning functions for S/HMO clients. These arrangements worked well in one facility, but created "turf" problems at the one hospital most S/HMO clients preferred.

The case manager had to coordinate with a number of independent contracted medical specialists at the principal hospital, because the S/HMO primary care physicians did not have admitting privileges. Since there were no financial incentives for the medical specialists to promote early discharge, the S/HMO case manager reported being unable to reduce hospital lengths of stay. At best, the S/HMO case manager role in the principal hospital was "tolerated." In the other two hospitals (which were not highly utilized by S/HMO members), no problems were reported with the roles or relationships between the hospital staff and the S/HMO case manager.

At Seniors Plus, the majority of S/HMO clients received hospital care in two contracted facilities. Utilization review and discharge planning for hospitalized S/HMO clients was not a case manager responsibility. These functions were performed by the Group Health continuing care department responsible for hospital discharge planning and short-term post-acute care for

all GHI members. This department worked closely with the case managers and turned the case over to S/HMO case management when long-term chronic care services were needed. Unlike Medicare Plus II, where there seemed to be a general unawareness of the S/HMO and its potential benefits for plan members, the Seniors Plus GHI continuing care unit was knowledgable about the S/HMO and viewed it as a valuable insurance benefit for its members.

At SCAN Health Plan, acute hospital care for S/HMO clients was contracted from St. Mary Medical Center. Hospital utilization review was performed by the SHP medical director. Discharge planning for all unplanned admissions was the responsibility of the St. Mary discharge planners, who notified case managers if the client needed long term care services. Discharge planning for all planned hospital admissions was the responsibility of one SHP case manager.

As mentioned above, there were a variety of problems related to hospital utilization and discharge planning. At the end of the second year of the demonstration, S/HMO medical directors and designated case managers for planned hospital admissions were attempting to reduce hospital lengths of stay. On the other hand, the S/HMO staff had no authority to deny payment for unnecessary hospital days; consequently, their efforts had little or no impact on utilization. At the end of the second year of the demonstration, coordination of the contracted primary care physicians and specialists, the S/HMO case managers, and the hospital discharge planners was reportedly improving somewhat, but there were still a number of unresolved issues.

NURSING HOME SERVICES

Medicare Plus II, like the larger Kaiser HMO, used outside SNFs and ICFs for nursing home care. Kaiser was expecting to develop formal care contracts with long term care vendors in late 1987, but for the first two years of the demonstration, the S/HMO paid a nursing home its usual per diem rate for SNF/ICF care. The case managers primarily used six dually licensed SNF/ICF facilities as vendors for nursing home care. Although the S/HMO case managers made arrangements for the nursing home placements, responsibility for monitoring the quality of care and discharge planning rested with the Kaiser SNF review coordinator. The Kaiser SNF coordinator in turn coordinated with the S/HMO case manager when the member was eligible for chronic care benefits. The case managers were not satisfied with the quality of care in several of the homes. Further, it was reported that many of the homes provided and billed for services without obtaining prior authorization from a S/HMO case manager.

At Elderplan, SNF and HRF care were provided in two facilities owned and operated by MJGC, the S/HMO sponsor. One S/HMO case manager performed all nursing home utilization review and discharge planning for S/HMO clients placed in nursing homes. These arrangements were reportedly working well.

At Seniors Plus, the partnership agreement specified that Ebenezer Society would be responsible for nursing home services. In addition to

Ebenezer, which provided the majority of care for S/HMO clients in its four facilities, any nursing home in the community could also be used under a contractual arrangement with Ebenezer. All nursing home utilization review and discharge planning for S/HMO clients was the responsibility of the Group Health geriatric nurse practitioner, who worked closely with the S/HMO managers.

At SCAN Health Plan, nursing home services were provided to S/HMO clients at St. Mary in specially designated beds or at another nursing home under contract to St. Mary. One S/HMO case manager was responsible for all nursing home utilization review and discharge planning. No problems were reported with these working relationships.

COMMUNITY-BASED AND IN-HOME SERVICES

At Medicare Plus II, the majority of in-home services for S/HMO members were provided by Kaiser's own certified home-health agency -- which also operated its own hospice program and chronic care program. If a S/HMO member qualified for home care under traditional Medicare regulations, the S/HMO case managers were not involved in the care plan or monitoring. If services were to be covered under the chronic care benefit, the person was transferred to a S/HMO case manager for follow-up. The S/HMO also used two outside home-health agencies, primarily when seven day a week or night coverage was needed. Two adult day care programs in the community were used was needed. The S/HMO did not have formal contracts with these community agencies, but no access or quality of care problems were reported. The S/HMO case managers were responsible for finding an available vendor, authorizing the level of services, and terminating the services when appropriate.

At Elderplan, in-home services were provided under a contract with the parent agency, MJGC, which operated a certified home-health agency. Additional homemaker, housekeeper and personal care services were contracted with six vendors. Medical day care was also provided by a MJGC unit. Home-delivered meals, social day care, and medical transportation were provided under contractual arrangements with community agencies. The S/HMO case managers were responsible for authorizing, monitoring, and when appropriate, terminating all the community-based and in-home services available under the chronic benefit. No problems were reported with the vendor agencies or the quality of services.

At Seniors Plus, community services were provided to clients primarily through the sponsoring agency, Ebenezer Society, including a comprehensive range of home-health services, adult day care, respite care and a senior companion program. Ebenezer also made arrangements for additional home-care services with two community vendors. Medical transportation was contracted through several cab companies. The case managers were responsible for authorizing, monitoring, and terminating, if appropriate, all chronic care services. The working relationships between S/HMO case managers and Ebenezer were strong and positive. Ebenezer had established procedures for monitoring the quality of their services, and no problems were reported with the other

outside vendors.

At SCAN Health Plan, long-term care community-based and in-home services were all provided under contract with outside vendors. There were over 40 vendor agencies, each with a prenegotiated fee. SCAN had previously worked with many of these agencies on other long term care projects. Vendors were responsible for monitoring their own quality of care. However, the director of case management met with active vendors every six months to discuss any problems or issues. No particular problems were reported with the vendors. The case managers were responsible for contacting individual vendors, arranging for the services, and monitoring the chronic care budget.

Attachment B

S/HMO CASE MANAGEMENT STAFFING PATTERNS

(Fourth Quarter 1986)

Position	Qualifications	FTE	Specialized Functions
MEDICARE PLUS II			
Project Administrator	MA Speech Pathology	.75	-- Develop the demonstration protocol, the benefit package, and the assessment tool
			-- Set policy regarding case management and expanded care services
			-- Coordinate the SHMO with the Kaiser system and the community
			-- Allocate twenty percent of time to client case management
Lead Resource Coordinator	RN	1.0	-- Develop S/HMO MIS; also function as the liaison with the Kaiser Computer Programming Department
			-- Allocate fifty percent of time to client case management
Lead Resource Coordinator	MSW	1.0	-- Lead/supervise the Resource Coordination Team; handle intake, case assignment, and reliability of the health assessments
			-- Allocate fifty percent of time to client case management
Resource Coordinator	RN	.5	-- Provide client case management
Resource Coordinator	MSW	.8	-- Provide client case management
Resource Coordinator	BA	1.0	-- Provide client case management
Resource Coordinator	BA	.5	-- Provide client case management
Program Assistant		.5	-- Perform primary clerical tasks
SENIOR PLUS			
Service Coordination Director	MSW	1.0	-- Refine the basic model of operation of the service coordination unit
			-- Monitor and control utilization of long term care services
			-- Participate in selection and management of service contracts with outside long term care service providers
			-- Hire and supervise the service coordinators
			-- Allocate twenty-five percent of time to client case management
Service Coordinator	RN	1.0	-- Provide client case management
Service Coordinator	BSW	1.0	-- Provide client case management
Administrative Assistant	BA	1.0	-- Maintain the utilization/claims system for long term care services
Secretary		.5	-- Perform clerical tasks

Position	Qualifications	FTE	Specialized Functions
SCAN HEALTH PLAN			
Director of Case Management	MSW ACSW	.75	-- Manage and direct the case management department
			-- Monitor the case management department budget, establish contracts for the purchasing of services, set vendor rates
			-- Supervise of the case management nurse supervisor as well as the staff physical therapist, the SNF Liaison RN, the Health Education Coordinator, and the Member Service Representative responsible for complaints and grievances
Case Management Nurse Supervisor	RN MSG	1.0	-- Provide day to day supervision of the case managers, including reviewing cases and authorizing services
			-- Assess the needs of hospitalized members and provide care planning for timely discharge
			-- Review member health histories
			-- Conduct nursing evaluations
Case Manager	MSW/MSG	1.0	-- Provide client case management
Case Manager	MSW/MSG	1.0	-- Provide client case management
Case Manager	MSW/MSG	1.0	-- Allocate fifty percent of time to the case management MIS -- Allocate fifty percent of time to client case management
Case Manager	BSW	1.0	-- Provide client case management
Case Manager	BSW	1.0	-- Provide client case management
Case Manager	MSW	.2	-- Verify/monitor health status by telephone follow-up and in-home visits
Hospital/SNF Liaison	RN	.5	-- Provide discharge planning for all elective surgeries and planned hospital admissions
			-- Provide discharge planning of all SNF patients
Physical Therapist	RPT	.5	-- Assess physical therapy needs and provide service
			-- Purchase durable medical equipment and provide liaison with vendors
Case Management Clerk		1.0	-- Perform clerical tasks
Secretary		1.0	-- Perform secretarial responsibilities

Position	Qualifications	FTE	Specialized Functions
ELDER PLAN			
Case Management Director	ACSW	1.0	-- Direct the case management department
			-- Coordinate with the medical group, the nursing homes, and the hospitals
			-- Review all health assessments and care plans
			-- Approve all service plans
Utilization Review Coordinator Case Manager	RN	1.0	-- Perform utilization review and discharge planning
			-- Monitor SNF patients and assist with discharge planning
Case Manager	RN	1.0	-- Provide client case management
Case Manager	ACSW	1.0	-- Provide client case management
Case Manager	ACSW	1.0	-- Provide client case management
Case Management Systems Coordinator		1.0	-- Process service utilization forms and other data
Secretary		1.0	-- Perform clerical tasks